

**CERTIFICATION FORM FOR ISSUANCE OF A
SPECIAL LICENSE PLATE OR CERTIFICATE FOR THE DISABLED**

If a doctor certifying an individual, complete Part 1. If an organization providing transportation for the disabled, complete Part 2.

PART 1: TO BE COMPLETED BY A LICENSED PHYSICIAN

Name of Physician: _____

Address _____

City, State, Zip _____

I hereby certify that _____ is or has been a patient under my care and is disabled either permanently or temporarily as indicated below.

CIRCLE ONE: PERMANENTLY TEMPORARILY

Check the appropriate box or boxes A through E, which defines the patient's condition(s).

- ☐ (A) Cannot walk one hundred (100) feet without stopping to rest;
- ☐ (B) Cannot walk without the use of or assistance from a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device;
- ☐ (C) Is restricted by lung disease to such an extent that the person's forced respiratory expiratory volume for one (1) second, when measured by spirometry, is less than one (1) liter, or the arterial oxygen tension is less than sixty (60) mm/hg on room air at rest;
- ☐ (D) Uses portable oxygen; or
- ☐ (E) Has a cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV according to standards set by the American Heart Association;

Signature of Physician _____ Date _____

PART 2: TO BE COMPLETED BY AN ORGANIZATION

Name of Organization _____

Address _____

City, State, Zip _____

Federal Employer Identification Number _____

- ☐ (F) This is to certify that the organization above owns a vehicle used primarily for transporting persons with disabilities as defined in items (A) through (E) in Part 1.

Signature of Authorized Official _____ Date _____

IMPORTANT NOTICE ON BACK